DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 6

2. STATE: WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 279,085
b. FFY 2001 $1,116,340

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19D pages 1-35a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19D pages 1-35

10. SUBJECT OF AMENDMENT:
plan clean up and addition of new Section 21 to provide for special legislative appropriations in the rate setting methodology

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
NO COMMENTS

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Iris Oleske

13. TYPED NAME:
GARRY L. MCKEE, PH.D., M.P.H. IRIS OLESKE

14. TITLE:
DIRECTOR STATE MEDICAID AGENT

15. DATE SUBMITTED:
July 18, 2000

16. RETURN TO:
Iris Oleske
State Medicaid Agent
Wyoming Department of Health
Office of Medicaid
154 Hathaway Building
Cheyenne, WY 82002

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 25, 2000

18. DATE APPROVED:
7/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/00

20. SIGNATURE OF REGIONAL OFFICIAL:
Hastings

21. TYPED NAME:
~~Paul R. Jones, MD~~ David R. Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: July 20, 2000

FORM HCFA-179 (07-92)

Instructions on Back

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Section 1. Authority

This State Plan Amendment is prepared and submitted to HCFA for approval pursuant to 42 U.S.C. § 1396(a) (b) and 45 C.F.R. Part 201 Subpart A.

Section 2. Purpose and applicability.

This Attachment establishes methods and standards to establish Medicaid reimbursement rates for nursing facilities which provide services to recipients. It shall apply to and govern all payments of Medicaid funds to facilities for services furnished on or after July 1, 2000.

Section 3. General provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this Attachment is the standard terminology and has the standard meaning used in accounting, health care and Medicaid.

(b) Cost terms and hierarchy. This Attachment includes the following cost terms, even though such cost may not be reimbursable because of other provisions of this Attachment, in the following hierarchy:

(i) General ledger cost;

(ii) Reported cost;

(iii) Non-allowable cost;

(iv) Allowable cost;

(v) Reimbursable cost; and

(vi) Cost that must be incurred.

(c) General methodology.

(i) Costs related to direct patient care are more likely to benefit quality of patient care than indirect costs.

(ii) Costs incurred in the actual delivery of patient care are more likely to contribute to the quality of care offered by a facility than costs incurred at a distance from the delivery of services.

(iii) If not otherwise specified in this Chapter, the Department shall determine per diem rates using the methodology set forth in the Medicare Provider Reimbursement Manual ("PRM") and HCFA instructions for administering the PRM, both of which are incorporated by this reference. The PRM and the HCFA instructions are published by HCFA and are available from that agency. The PRM is also published in the CCH Medicare and Medicaid Guide, and is available from Commerce Clearing House, 4025 West Peterson Avenue, Chicago, Illinois 60646.

(d) The Department may issue Manuals, Provider Bulletins, or both, to providers and/or other affected parties to interpret the provisions of this Chapter. Such Manuals and Provider Bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

Section 4. Definitions.

(a) "Allowable cost." Cost properly included as patient-related costs on the cost report. The cost must contribute directly or indirectly to patient care.

(b) "Annualized eight quarter average rate of change in the inflation factor." The eight quarter average rate of change in the inflation factor is computed by adding together the annualized rate of change in the inflation factor for each of the most recent eight quarters and dividing that sum by eight, with the product rounded to three places to the right of the decimal.

(c) "Average level of care." The average score received by recipients of a facility on the evaluations of medical necessity performed pursuant to Chapter 22. The average level of care shall be computed for each facility using the scores on initial evaluations of medical necessity performed during the twelve months ending on October 1, 1993. The average shall be redetermined using the scores on initial evaluations performed during the twelve months ending on July 1, 1993, and annually thereafter.

(d) "Base rate." The per diem rate in effect for a facility on June 30, 1995.

(e) "Capital costs." Costs incurred by a facility for construction, depreciation, interest, rent and leases.

(f) "Change of ownership." A change in a provider's ownership, control, operation or leasehold interest.

(g) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

(h) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(i) "Chapter 5." Chapter 5, Wyoming Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

(j) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(k) "Chapter 22." Chapter 22, Nursing Facility Evaluation of Medical Necessity, of the Wyoming Medicaid Rules.

(l) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(m) "Common ownership." Common ownership exists if an individual or entity possesses significant ownership or equity in the provider and the entity providing services, supplies or property to the provider.

(n) "Consumer price index." The consumer price index for All Urban Consumers (CPI-U) (United States city average), as determined by the United States Department of Labor and Statistics.

(o) "Contracted rate." A rate, determined pursuant to Section 23, that the Division agrees to pay a provider for value-added performance.

(p) "Control." An individual or entity that has the power, directly or indirectly, to significantly influence or direct the actions or policies of another individual or entity.

(q) "Cost report." An itemized statement of a facility's historical costs for the most recently completed fiscal period, prepared in accordance with GAAP, these regulations and the cost report instructions, and submitted on the most recent version of the Wyoming Financial and Statistical Report for Nursing Facilities. "Cost report" includes any supplemental requests by the Department for additional information.

(r) "Cost that must be incurred." A cost that must be incurred by an efficiently and economically operated facility.

(s) "Credit balance." Medicaid funds received by a provider that are owed to the Department for any reason.

(t) "Department." The Wyoming Department of Health, the single state agency appointed pursuant to 42 U.S.C. § 1396a(a) (5), its agent, designee or successor.

(u) "Desk review." A review by the Department of a facility's cost report to determine: (1) if the cost report has been prepared and submitted in compliance with this Attachment; (2) that costs have been properly allocated; (3) that costs are allowable; (4) that income is shown to reduce applicable costs; and (5) that all costs are reasonable and ordinary. A facility may not request that the Department perform a desk review.

(v) "Dodge Construction Index." The Dodge Construction Index for Nursing Homes.

(w) "Excess payments." "Excess payments" as defined in Chapter 39, which definition is incorporated by this reference. In addition, "excess payments" includes Medicaid funds received by a provider in excess of the provider's per diem rate, or which were received pursuant to a per diem rate which is subsequently determined to be erroneous or based on erroneous information.

(x) "Extraordinary recipients." Recipients that require ventilator care.

(y) "Facility." A nursing facility (NF) that meets all of the requirements of state licensure and certification for participation in the Medicaid program. "Facility" may include a distinct part of a hospital or institution which is designated to provide NF services.

(z) "Fair market value. " The price a prudent buyer would pay a seller in an arms-length transaction.

(aa) "Field audit." An examination, verification and review of a facility's financial records and any supporting or related documentation conducted by employees, agents or representatives of the Department or HCFA. A facility may not request that the Department perform a field audit.

(bb) "Financial records." All records, in whatever form, used or maintained by a facility in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the facility's cost reports, including all such information regarding home office expenses.

(cc) "General ledger cost." A cost properly recorded on a facility's general ledger in accordance with GAAP. This includes cost incurred at an individual facility as well as central office or pooled cost reasonably allocated to an individual facility.

(dd) "Generally accepted accounting principles (GAAP)." Accounting concepts, standards and procedures established by the American Institute of Certified Public Accountants.

(ee) "Generally accepted auditing standards (GAAS)." Auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(ff) "HCFA." The Health Care Financing Administration of the United States Department of Health and Human Services, or its agent, designee, or successor.

(gg) "Historical cost." The general ledger costs properly reported on the cost report by a facility during the fiscal period immediately preceding the rate period for which the per diem rate is effective.

(hh) "Incentive allowance." A component of the per diem rate paid to those providers that meet the criteria of Section 20.

(ii) "Inflation factor." The SNF Market Basket as published quarterly by DRI/McGraw-Hill.

(jj) "Interim payments." Payments to a new facility during the time between the effective date of the new facility's provider agreement and the determination of a per diem rate pursuant to this Attachment.

(kk) "Investment income." "Investment income" as defined pursuant to the PRM, which definition is incorporated by this reference.

(ll) "Licensed bed." A bed in a facility for which the facility has been licensed by the Medical Facilities Office of the Department.

(mm) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act, as amended, and the Wyoming Medical Assistance and Services Act, as amended. "Medicaid" includes any replacement or successor program enacted by Congress or the Wyoming Legislature.

(nn) "Medicaid program services." Services, other than nursing facility services, which are Medicaid reimbursable pursuant to the Attachments and policies of the Department. "Medicaid program services" excludes services and supplies included in the per diem rate, or services and supplies included in a negotiated rate.

(oo) "Medically necessary" or "medical necessity." "Medically necessary" or "medical necessity" as those terms are defined in Chapter 3, which definition is incorporated by this reference.

(pp) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(qq) "Negotiated rate." The rate, not to exceed actual costs to the facility, which the Department agrees to pay for services provided to an extraordinary recipient in lieu of the facility's per diem rate.

(rr) "New facility." A newly constructed facility, a newly designated portion of a hospital which has not previously been designated as a facility, or an existing facility which has not previously been certified. An addition to a certified facility is not a "new facility."

(ss) "Nonallowable cost." Costs which are not reasonably related to services included in the Medicaid per diem rate, or which are against public policy. Contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are adjustments to revenue and, therefore, are not included in allowable cost. Nonallowable costs also include, but are not limited to:

(i) Advertising expense (other than help wanted ads and telephone directory expense);

(ii) Attorney fees and other costs associated with negotiations, administrative proceedings or litigation involving the Department, except as specified in settlement;

(iii) Bad debts;

(iv) Cost arising from joint use of resources (including central office and pooled cost) not reasonably related to patient care;

(v) Capital costs due solely to changes in ownership;

(vi) Costs incurred in transactions with organizations related to the provider by common ownership or control, to the extent that such costs exceed the limits established under 42 C.F.R. 413.17, which limits are hereby incorporated by reference;

(vii) Costs incurred as a result of enforcement actions taken by the Department pursuant to Chapter 5 and/or HCFA in response to facility deficiencies, including costs of directed in-service training, suspended or denied per diem payments, recipient reimbursement expenses, transfer costs, and costs relating to state monitoring and/or the appointment of a temporary manager.

(viii) Costs not reasonably related to patient care;

(ix) The costs associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs;

(A) For per diem rates with a rate effective date on or after May 1, 1996, and before July 1, 1997, forty-five (45%) percent of the costs identified pursuant to this paragraph shall be nonallowable costs, and fifty (50%) percent of Medicare bed days shall be removed.

(B) For per diem rates with rate effective dates on or after July 1, 1997, ninety (90%) percent of the costs identified pursuant to this paragraph shall be nonallowable costs, and one-hundred (100%) percent of Medicare bed days shall be removed.

(C) When determining the capital component for facility's with occupancy below ninety (90%), Medicare days will be imputed to reflect Medicare occupancy.

(x) Costs related to the acquisition, establishment or operation of an in-house pharmacy, other than the reasonable costs of a pharmacy consultant;

(xi) Costs related to extraordinary recipients that exceed the per diem rate;

(xii) Costs related to hospice services;

(xiii) Costs (such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies) which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger after July 17, 1984, for which any Medicaid payment has been previously made;

(xiv) Costs which exceed the costs which must be incurred by an efficiently and economically operated facility, except as otherwise allowed by this Chapter.

(xv) Federal income and excess profit taxes;

(xvi) Fees paid to directors and salaries, wages or fees paid to non-working officers, employees or consultants;

(xvii) Fund-raising expenses;

(xviii) Interest or penalties on federal or state taxes;

(xix) Judgments entered against a facility or settlements entered into by a facility arising out of actions or inactions of the facility's agents or employees, including judgments entered against a facility's agent or employee that a facility pays, or settlements involving the facility's agent or employee that the facility pays.

(xx) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(xxi) Meals and lodging provided to guests and employees. If the cost cannot be ascertained, the revenue from meals and lodging furnished to guests and employees shall be offset against the appropriate cost;

(xxii) Prescription drugs;

(xxiii) Public relations expenses;

(xxiv) Resident personal purchases;

(xxv) Return on equity;

(xxvi) Self-employment taxes;

(xxvii) Stockholder relations or stock proxy expenses;

(xxviii) Taxes or assessments for which exemptions are available;

(xxix) Telephone, television and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients;

(xxx) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(xxxi) Vending machine and related supplies.

(tt) "Nursing facility." A nursing facility as defined by 42 U.S.C. § 1396r(a), which is incorporated by this reference.

(uu) "Nursing facility services." Nursing facility services" as defined in 42 U.S.C. § 1396d(f), which is incorporated by this reference.

(vv) "Occupancy." As used in minimum occupancy calculations means the ratio of patient days for a cost report time period to total licensed bed days available for the same time period. Both patient days and total licensed bed days available shall apply to the same facility beds, either the entire licensed facility or only to the certified portion of a facility, depending on a facility's cost finding methodology.

(ww) "OSCAR report." The online Survey, Certification and Reporting (OSCAR) summary report of survey findings.

(xx) "Overpayments." "Overpayments as defined in Chapter 39, which definition is incorporated by this reference.

(yy) "Patient." A resident of a facility.

(zz) "Patient day." That period of service rendered to a patient between the census-taking hours on two successive days. "Patient day" does not include any day that a patient was temporarily absent.

(aaa) "Patient-related costs." Reasonable and ordinary costs which contribute directly or indirectly to patient care. Restricted grants and gifts must be offset against related expense for purposes of determining patient-related costs.

(bbb) "Patient-related services." Services provided directly or indirectly to patients.

(ccc) "Per diem cost." Cost component cost divided by patient days. Cost component costs, patient days and licensed beds shall be for the same time period.

(ddd) "Per diem rate." The Medicaid allowable payment, as determined pursuant to this Chapter, for services furnished by a facility to a recipient, including the inflation adjustment and the incentive allowance, if any.

(eee) "Permanent financing." Financing attendant to the acquisition of patient-related tangible assets.

(fff) "Pooled costs." Costs incurred outside the facility by a provider that owns more than one facility or by a person or entity that owns, manages or controls a facility.

(ggg) "Private pay rate." The patient day weighted average of the daily rates a facility charges to non-recipients, other than Medicare recipients, after all discounts, allowances and subsidies are subtracted, for the same or similar services, as of the ninetieth (90th) day after the end of the facility's fiscal period, as defined by paragraph 5(c)(vi). "Private pay rate" does not include the cost of Medicare Part A and/or Part B premiums or deductibles, or the cost of any other insurance premiums or deductibles.

(hhh) "Provider." "Provider" as defined in Chapter 3, which definition is incorporated by this reference. "Provider" includes a facility which previously had a provider agreement.

(iii) "Provider agreement." "Provider agreement" as defined in Chapter 3, which definition is incorporated by this reference.

(jjj) "Quality of care." The quality of care provided by a facility as measured by the number of Level A deficiency citations, or their equivalent or successor as determined by the Department in conformance with applicable Federal statutes and regulations, received by the facility on the latest survey and taking into consideration the number of validated complaints involving the facility. The quality of care shall be determined effective October 1, 1993, and shall be redetermined effective each July 1 thereafter using the results of the latest completed survey as summarized on the OSCAR report and the number of validated complaints regarding the previous twelve months. For purposes of this definition, "validated complaints" means written complaints which are validated by the survey agency.

(kkk) "Rate effective date." The first day of the fifth month after the end of the facility's fiscal year.

(lll) "Recipient." A person that has been determined eligible for Medicaid.

(mmm) "Reimbursable cost." Allowable cost, subject to the cost component limitations established pursuant to this Chapter. Reimbursable cost must be equal to or less than allowable cost and must be equal to or greater than cost that must be incurred.

(nnn) "Related to the provider." The provider to a significant extent is associated or affiliated with or has control of or is controlled by an individual or entity.

(ooo) "Reported cost." General ledger cost properly reported on the cost report. It is composed of allowable cost and nonallowable cost.

(ppp) "Representation statement." A written statement, in the form specified by the Department, which specifies the persons or entities which have assumed the assets and liabilities of a facility.

(qqq) "Reserved bed." A licensed bed in a facility reserved for a recipient who is temporarily absent.

(rrr) "Services." "Nursing facility services" as defined in 42 U.S.C. § 1396d(f), which is incorporated by this reference.

(sss) "Services and supplies included in the per diem rate." Services and supplies used in providing patient-related services, including, but not limited to those specified in Attachment A, which is incorporated by this reference.

(ttt) "Services and supplies not included in the per diem rate." Services and supplies which are not included in the per diem rate include, but are not limited to:

(i) Audiology services;

(ii) Barber and beauty shop services other than routine personal hygiene items and services;

(iii) Cigarettes, cigars, pipes and tobacco;

(iv) Clothing;

(v) Cosmetics;

(vi) Dental services (unless under purchase for service contract);

(vii) Dry cleaning;

(viii) Eye examinations and other optical supplies and services;

(ix) Hearing aids;

(x) Hospital services;

(xi) Laboratory services;

(xii) Orthotic services;

(xiii) Physician services;

(xiv) Podiatry services;

(xv) Prosthetic devices;

(xvi) Ventilators; and

(xvii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs, including batteries.

(uuu) "Survey." A survey, including extended or special surveys, performed pursuant to Pub. L. No. 100-203, §4213 100 Stat. 1330-207 (codified at 42 U.S.C. § 1396r(g)).

(vvv) "Temporary absence" or "temporarily absent." When a recipient is out of a facility for hospitalization, therapeutic home visits, or for any other reason, and is expected to return to the facility.

(www) "Usual and customary." The facility's private pay rate.

(xxx) "Working capital." Patient-related financing other than permanent financing.

(yyy) "Working day." A day on which the offices of the State of Wyoming are open for transacting business.

Section 5. Submission and preparation of cost reports.

(a) Time of submission. Complete cost reports shall be submitted by the first working day of the fourth month following the end of the fiscal period, as defined in paragraph (c) (vi).

(i) Complete cost report. A cost report shall be deemed complete upon receipt of the completed and certified cost report and the information specified in subparagraphs (c) (iii) (A-F). The per diem rate shall not be computed, however, until the receipt of the information specified in subparagraphs (c) (iii) (A-J). The Department may request additional information, such request to be in writing sent by certified mail, return receipt requested. Any such information must be submitted, by certified mail, return receipt requested, within thirty days after the date of the request. A cost report may not be amended after submission.

(ii) Extension. A sixty (60) day extension of the submission date shall be granted by the Department for good cause if requested by a provider in writing prior to the due date. A cost report shall not be deemed past due while an extension term is in effect. Only one request for an extension may be granted for each cost reporting period.

(b) Failure to timely submit cost report. If a cost report, including the information specified in subparagraphs (c) (iii) (A-F) and any information requested pursuant to paragraph (a) (i), is more than ten (10) days past due, the Department shall reduce the per diem rate by twenty-five percent (25%) until all missing information is received in writing in the form specified by the Department. If the cost report, including the information specified in subparagraphs (c) (iii) (A-F), is more than sixty (60) days past due, the Department shall suspend all Medicaid payments until all missing information is received in writing in the form specified by the Department. Upon receipt of a complete cost report that has been prepared in accordance with this Attachment, the penalty will be refunded, without interest. This remedy does not affect the Department's right to withhold per diem payments, terminate provider participation or invoke other remedies permitted by applicable statutes and Attachments.

(c) Preparation of cost reports.

(i) Cost reporting must be reasonable and consistent within a facility, between Medicaid certified and noncertified parts where such distinction is utilized for cost finding, among multiple facilities under the same ownership or control, and over time.

(ii) Allocation of costs. Costs must be allocated pursuant to the cost report.

(iii) Required information. Authenticated copies of significant agreements and other documentation must be attached to the cost report. This material includes:

(A) Contracts or agreements involving the purchase of facilities or equipment during the last seven years, unless previously submitted;

(B) Contracts or agreements with owners or parties related to the provider, unless previously submitted;

(C) Leases regarding real or personal property, unless previously submitted;

(D) Management contracts, unless previously submitted;

(E) Mortgages and loan agreements, unless previously submitted;

(F) Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications;

(G) Audit, review or compilation statements prepared by an independent accountant that includes facility costs or allocation of costs to the facility, including disclosure statements and management letters or SEC Forms 10-K;

(H) Home office cost statement;

(I) Medicare cost report;